

## (B) MEDICAL PROGRAMS

- Employees in the IBEW Union (hired prior to 8/1/06)
- Non-Medicare-Eligible IBEW Employees (retired between 8/1/00 and 7/31/06)
- IBEW Non-Medicare-Eligible Participants on LTD (terminated between 8/1/00 and 7/31/06)

	<b>CIGNA OAP</b>			<b>Vytra PPO</b>		
	<b>In-Network</b>	<b>Out-of-Network</b>	<b>Aetna (HMO)</b>	<b>In-Network</b>	<b>Out-of-Network</b>	<b>HIP (HMO)</b>
<b>Medical Care Provider</b>	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician/facility	Participating physician/facility
<b>Payment of Benefits</b>	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms
<b>Age Limit for Dependent Children/Full-Time Student</b>	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23
<b>Annual Deductible</b> (Individual/Family)	N/A	\$250/\$650	N/A	N/A	\$250/\$650	N/A
<b>Annual Out-of-Pocket Maximum</b> (Indiv/Family) (Excl. Deductible)	N/A	\$1200/\$2400	\$1500/\$3000	N/A	\$1200/\$2400	N/A
<b>Lifetime Maximum Benefit</b>	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
<b>Pre-Existing Condition Limitation</b>	N/A	N/A	N/A	N/A	N/A	N/A
<b>Office Visits</b>	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full after \$5 co-pay	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full
<b>Emergency Room</b> (Accident/Illness)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after \$35 co-pay (waived if admitted)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after \$50 co-pay (waived if admitted)
<b>Inpatient Hospital</b> (Semi-Private Room, Board, Services, Supplies)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
	Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.			Pre-admission certification required or \$250 penalty plus 50% reduction in benefits on any days not approved.		
(Physician/Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	80% of R&C after deductible	Covered in full
<b>Second Surgical Opinion</b> (Office Visit)	Covered in full	100% of R&C	Covered in full after \$5 co-pay	Covered in full	100% of R&C	Covered in full
<b>Laboratory/X-Ray</b>	Covered in full	80% of R&C after deductible	Lab: Covered in full X-Ray: Covered in full after \$5 co-pay	Covered in full	80% of R&C after deductible	Covered in full
<b>Maternity</b> (Initial Visit To Determine Pregnancy)	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full after \$5 co-pay	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	80% of R&C after deductible	Covered in full
<b>Prescription Medication</b> (Retail)	\$5 generic/\$10 brand (up to 30-day supply)	80% of R&C after deductible	\$5 generic/\$10 brand formulary/\$25 brand non-formulary (up to 30-day supply)	\$5 generic/\$10 brand (up to 30-day supply)	80% of R&C after deductible	\$5 generic/\$10 brand (up to 30-day supply)
(Mail Order)	\$10 generic/\$20 brand (up to 90-day supply)	Use in-network benefit	\$10 generic/\$20 brand formulary/\$50 brand non-formulary (31 to 90-day supply)	\$10 generic/\$20 brand (up to 90-day supply)	In-network only	\$7.50 generic/\$15 brand (up to 90-day supply)

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	CIGNA OAP		Aetna (HMO)	Vytra PPO		HIP (HMO)
	In-Network	Out-of-Network		In-Network	Out-of-Network	
<b>Preventive Care</b> (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 19)	80% of R&C after deductible	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full after \$5 co-pay	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after \$5 co-pay	Covered in full	80% of R&C after deductible	Covered in full
(Physical Exam)	Covered in full after \$10 co-pay	Not covered	Covered in full after \$5 co-pay	Covered in full after \$10 co-pay	Not covered	Covered in full
(Routine Eye Exam)	Not covered	Not covered	Covered in full after \$5 co-pay	Covered in full after \$10 co-pay (1 exam/year)	Not covered	Covered in full (for optometrist in discount program)
<b>Mental Health Care</b> (Inpatient)	Same as inpatient hospital	Same as inpatient hospital	Covered in full	Same as inpatient hospital	Same as inpatient hospital	Covered in full
(Outpatient)	Covered in full after \$10 co-pay/visit	80% of R&C after deductible	Covered in full after \$5 co-pay/visit	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full
<b>Substance Abuse Treatment</b> (Inpatient Detox)	Same as inpatient hospital	Same as inpatient hospital	Covered in full	Same as inpatient hospital	Same as inpatient hospital	Covered in full
(Outpatient Rehab)	Covered in full after \$10 co-pay/visit	80% of R&C after deductible	Covered in full after \$5 co-pay/visit	Covered in full after \$10 co-pay/visit	80% of R&C after deductible	Covered in full
<b>Alternate Care</b> (Home Health Care) Non-custodial	Covered in full (Max: 40 visits/year combined in and out of network)	80% of R&C after deductible	Covered in full after \$5 co-pay/visit (limited to 3 intermittent visits/day)	Covered in full (Max: 40 visits/year combined in/out)	80% of R&C after deductible	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility) Non-Custodial	Same as inpatient hospital (Max: 60 days/year combined in and out of network)	Same as inpatient hospital	Covered in full	Same as inpatient hospital (Max: 60 days/year combined in/out)	Same as inpatient hospital	Covered in full
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full after \$5 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after \$10 co-pay	80% of R&C after deductible	Covered in full (Max: 90 visits/year)
<b>Durable Medical Equipment</b>	Covered in full	80% of R&C after deductible	Not covered	Covered in full	80% of R&C after deductible	Covered in full
<b>External Prosthetic Devices</b>	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	80% of R&C after deductible	Covered in full
<b>Hearing Aids</b>	Covered in full ----- (Max: \$2000/1095 days) -----	80% of R&C after deductible	Not covered	Not covered	Not covered	Not covered

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